

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011042

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

99  
FILED MAR 26 1963VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>DeKalb</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>DeKalb</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sherman Township</b>		Length of stay in lb <b>10 years</b>	c. CITY OR TOWN <b>Amity</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rural (Home)</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R.F.D. #1</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>FRANKLIN</b> Last <b>SARGENT</b>		4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/15/1889</b>
9. AGE (last birthday) <b>73</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Stationery Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jersey Cereal</b>	
11. BIRTHPLACE (City and state or country) <b>Matkins Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>Norman Timothy Sargent</b>		13b. MOTHER'S MAIDEN NAME <b>Louisa Caroline Duffield</b>	
14. NAME OF HUSBAND OR WIFE <b>Mrs. Lucy E. Sargent</b>		Address <b>R.F.D. #1 Amity, Mo.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	
17. INFORMANT <b>Mrs. Lucy E. Sargent</b>		Address <b>R.F.D. #1 Amity, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Endocarditis</i> DUE TO (b) <i>Acute Infective Heart Disease</i> DUE TO (c) <i>Atherosclerosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>9 yrs</b> <b>1?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I, attended the deceased from <b>Feb 1954</b> to <b>3/14/63</b> and last saw him alive on <b>3/14/63</b> Death occurred at <b>1:30 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Harold Fowler M.D.</b>	
22b. ADDRESS <b>Mayville Mo</b>		22c. DATE SIGNED <b>3/16/63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/16/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	
23d. LOCATION (City, town, or county) <b>St. Joseph Missouri</b>		23e. DATE RECD. BY LOCAL REG. <b>3-20-1963</b>	
23f. FUNERAL DIRECTOR <b>James Funeral Home</b>		23g. ADDRESS <b>St. Joseph, Mo.</b>	
23h. SIGNATURE <b>[Signature]</b>		23i. REGISTRAR'S SIGNATURE <b>Lutice E. Davidson</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Charles E. Bennett*

Licensed Embalmer No. 4677

P. O. Address

*St. Joseph Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.